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8 **BEFORE THE**  
9 **BOARD OF REGISTERED NURSING**  
10 **DEPARTMENT OF CONSUMER AFFAIRS**  
11 **STATE OF CALIFORNIA**

12 In the Matter of the Accusation Against:

Case No.

2011-605

13 **HAZELLE LYN TICZON**  
14 **2550 E. Marlena Street**  
**West Covina, CA 91792**  
**Registered Nurse License No. 563563**

**ACCUSATION**

15 Respondent.

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17 Complainant alleges:

18 **PARTIES**

- 19 1. Louise R. Bailey, M.Ed., RN ("Complainant") brings this Accusation solely in her  
20 official capacity as the Executive Officer of the Board of Registered Nursing, Department of  
21 Consumer Affairs.  
22 2. On or about February 9, 2000, the Board of Registered Nursing issued Registered  
23 Nurse License Number 563563 to Hazelle Lyn Ticzon ("Respondent"). The Registered Nurse  
24 License was in full force and effect at all times relevant to the charges brought herein and will  
25 expire on July 31, 2011, unless renewed.

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1 8. California Code of Regulations, title 16, section 1443.5 states:

2 "A registered nurse shall be considered to be competent when he/she consistently  
3 demonstrates the ability to transfer scientific knowledge from social, biological and physical  
4 sciences in applying the nursing process, as follows:

5 "(1) Formulates a nursing diagnosis through observation of the client's physical condition  
6 and behavior, and through interpretation of information obtained from the client and others,  
7 including the health team.

8 "(2) Formulates a care plan, in collaboration with the client, which ensures that direct and  
9 indirect nursing care services provide for the client's safety, comfort, hygiene, and protection, and  
10 for disease prevention and restorative measures.

11 "(3) Performs skills essential to the kind of nursing action to be taken, explains the health  
12 treatment to the client and family and teaches the client and family how to care for the client's  
13 health needs.

14 "(4) Delegates tasks to subordinates based on the legal scopes of practice of the  
15 subordinates and on the preparation and capability needed in the tasks to be delegated, and  
16 effectively supervises nursing care being given by subordinates.

17 "(5) Evaluates the effectiveness of the care plan through observation of the client's physical  
18 condition and behavior, signs and symptoms of illness, and reactions to treatment and through  
19 communication with the client and health team members, and modifies the plan as needed."

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21 COST RECOVERY

22 9. Section 125.3 of the Code provides, in pertinent part, that the Board may request the  
23 administrative law judge to direct a licensee found to have committed a violation or violations of  
24 the licensing act to pay a sum not to exceed the reasonable costs of the investigation and  
25 enforcement of the case.

STATEMENT OF FACTS

10. At all relevant times, Respondent was employed as the Director of Nursing at Country Villa Novato Healthcare Center ("Country Villa"), a skilled nursing facility in Novato, California.

11. Patient A, a 39 year-old male, was admitted to County Villa on September 29, 2009, with diagnoses that included: a urinary tract infection, hypertension, congestive heart failure, chronic obstructive pulmonary disease, diabetes and morbid obesity.

12. At approximately 7:00 p.m., on October 5, 2009, Respondent was advised that Patient A was last seen at 5:00 p.m., and could not be found.

13. As of September 1, 2006, Country Villa had a "Resident Elopement" policy, to be instituted for when a resident was believed to be missing. This policy provided that "all incidents of missing residents are to be considered an emergency situation." The policy also set forth that a licensed nurse at the facility was to be notified and a search for the missing resident was to be immediately undertaken inside and outside the facility. If the resident was not located after the initial search, then the facility Administrator and Director of Nursing (Respondent), and others were to be notified. If the resident is not located within one hour, then the Resident Elopement policy mandated that the police were to be notified with the resident's identifying information. Within 24 hours, if the missing resident was still not located, the California Department of Public Health was to be notified.

14. Respondent advised the staff at Country Villa to not contact the police after a search of the facility failed to locate Patient A.

15. Respondent further advised staff to document that Patient A had left against medical advice ("AMA").

16. On October 8, 2010, the Novato Police Department was contacted regarding Patient A's disappearance. Respondent reported to the investigating officer that Patient A had advised staff at 5:00 p.m., that he wanted to leave the facility. The California Department of Health, Licensing and Certification Program was not notified of Patient A's disappearance until October 8, 2010.

17. In a subsequent interview, Patient A confirmed that he had left Country Villa without notifying the staff.

FIRST CAUSE FOR DISCIPLINE

(Incompetence – Failure to Ensure Safety of Missing Resident)

18. Respondent is subject to discipline for incompetence pursuant to Code section 2761, subdivision (a)(1), as defined in title 16, sections 1443 and 1443.5, in that she endangered the safety and wellbeing of Patient A, by directing staff to not contact the police after he was missing for more than one hour, as set forth above in paragraphs 10 through 17.

## SECOND CAUSE FOR DISCIPLINE

(Unprofessional Conduct – Failure to Follow Facility Policy and Procedures)

19. Respondent is subject to discipline for unprofessional conduct pursuant to Code section 2761, subdivision (a), by her failure to follow Country Villa's "Resident Elopement" policy when Patient A was reported as missing, as set forth above in paragraphs 10 through 16.

### THIRD CAUSE FOR DISCIPLINE

(Unprofessional Conduct – Dishonesty)

20. Respondent is subject to discipline for unprofessional conduct pursuant to Code section 2761, subdivision (a), by instructing staff to document that Patient A had left AMA and her telling the investigating officer with the Novato Police Department that Patient A had advised staff at 5:00 p.m., that he wanted to leave the facility. The facts in support of this allegation are set forth above in paragraphs 10 through 17.

## PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 563563, issued to Hazelle Lyn Ticzon.

2. Ordering Hazelle Lyn Ticzon to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3.

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3. Taking such other and further action as deemed necessary and proper.

DATED: 1/10/11

Louise R. Bailey  
LOUISE R. BAILEY, M.Ed., RN  
Executive Officer  
Board of Registered Nursing  
Department of Consumer Affairs  
State of California  
*Complainant*

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